Into the Mouths of Babes **Record Key#_____**

NC Dental Screening & Varnish Project Encounter Form

Date of Visit __ __/ __ __/__ __

Patient Medicaid ID # _____

Patient Name _____

Practice Name _____

Provider Name _____

Patient DOB __ __/ __ __/__ __

Sex

① Female
② Male

Race

① White not Hispanic
② Black not Hispanic
③ Hispanic
④ Am. Indian/Alask. Native
⑤ Asian or Pacific Islands
⑥ Unknown

PLEASE COLOR IN THE BUBBLE (CIRCLE) FOR EACH ANSWER.

Teeth and Conditions Present:

How many teeth are present?

Ⓐ 1-2
Ⓑ 3-4
Ⓒ 5-6
Ⓓ 7-8
Ⓔ 9-10
Ⓕ 11-12
Ⓖ 13-14
Ⓗ 15-16
Ⓘ 17-18
Ⓙ 19-20

How many perceived cavities?

Ⓐ 1-2
Ⓑ 3-4
Ⓒ 5-6
Ⓓ 7-8
Ⓔ 9-10
Ⓕ 11-12
Ⓖ 13-14
Ⓗ 15-16
Ⓘ 17-18
Ⓙ 19-20
Ⓚ None

Noted Presence of Intraoral Soft Tissue Pathology?

Ⓨ Ⓝ

If yes, check all that apply

Ⓐ Ulcer
Ⓑ Mucocele
Ⓒ Inflamed gingiva
Ⓓ Other
_____
_____
_____

Please check any or all that apply:

Ⓐ Early Tooth Eruption (< 6 months)
Ⓑ Overlapping/Crowded Incisors
Ⓒ Poor Parental Dental Health
Ⓓ Does the child go to bed with bottle/breast/cup?
Ⓔ Frequent Snacking (3x or more per day)
Ⓕ Enamel Defects/Pits
Ⓖ Prolonged Bottle/Breast Feeding (>1 year)
Ⓗ Well Water or non-fluoridated bottled water
Ⓘ Greater than 3 weeks (continuous) of liquid meds
Ⓙ None

Oral Healthcare Questions:

Ⓨ Ⓝ Does someone clean the child's teeth daily?

If yes, Who? (*mark only one*)

Ⓐ Parent
Ⓑ Grandparent
Ⓒ Sibling
Ⓓ Guardian
Ⓔ Not Reported

Ⓨ Ⓝ Do they use toothpaste with fluoride?

Ⓨ Ⓝ Does the child take fluoride supplements?

RX?
Ⓐ Pills
Ⓑ Drops
Ⓒ Not Reported

Ⓨ Ⓝ Does the child go to bed with bottle/breast/cup?

If Yes, *mark all that apply*:

Ⓐ Water
Ⓑ Milk
Ⓒ Juice
Ⓓ Soda/Soft Drink
Ⓔ Sugar Water
Ⓕ Other
Ⓖ Not Reported

Ⓨ Ⓝ Does the child use a pacifier?

If yes and dipped in anything, *mark all that apply*:

Ⓐ Milk
Ⓑ Juice
Ⓒ Soda/Soft Drink
Ⓓ Sugar Water
Ⓔ Other
Ⓕ Not Reported

Procedures:

Ⓨ Ⓝ Fluoride Varnish applied? Ⓨ Ⓝ Education done? Ⓨ Ⓝ Parent informed that dental referral is needed?

Ⓨ Ⓝ Was dental referral for cavities/pathology made by physician? If Yes, to whom? _____

⓪ ① ② ③ ④ ⑤ ⑥ Including this visit, how many times have the screening, education and dental varnish been provided?

Provider Signature_____ **Provider Medicaid #** _____